## NOTICE OF AN INVOLUNTARY TRANSFER OR DISCHARGE

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| Date Delivered: | | |
| To: ***(Resident)*** | | To: ***(Responsible Party's Name, Address and Telephone #)*** |
| From***: (Facility Administrator)*** | | Facility Name: |
| Facility Contact Person: | | Title: |
| Facility Street Address: | | Facility Contact Person's Telephone Number: |
| City: | State: Michigan | Zip Code: |

**THIS NOTICE IS TO ADVISE YOU THAT:**

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| ☐ | You will be transferred or discharged from this facility to: |
| ☐ | You will be transferred from Room # ____ in the part of the facility you are in now to Room # _____ within this licensed facility. |

Effective date of transfer:

Reason for the Move:

(Continue on Pg. 2)



The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability, or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this Agency.

You have a right to appeal the nursing home's decision to transfer you. If you think you should not have to leave this facility, you may file a request for a hearing with the Michigan Department of Community Health within ten (10) days after receiving this notice. If you request a hearing, it will be held at least seven (7) days after your request, and you will not be transferred during that time. If you lose the hearing, you will not be transferred until at least 30 days after you received the original notice of the discharge or transfer and a discharge/transfer plan is completed and approved by the Department. A form to appeal the nursing home's decision and to request a hearing is attached along with a postage-paid envelope addressed to the Michigan Department of Community Health. (Time frames may vary for special situations identified in MCL 333.21773.)

The mailing address for the appeal is:

Michigan Department of Community Health
Bureau of Health Systems, Division of Operations
Complaint Investigation Unit
P.O. Box 30664
Lansing, Michigan 48909 (Street Address: 611 W. Ottawa Street; Lansing, Michigan 48933)

If you have any questions regarding this procedure you may call the Involuntary Transfer Coordinator with the Division of Operations at (517) 241-4712 or send a fax to (517) 241-0093 for assistance.

Before the hearing you or your representative will be able to see any of the facility's records pertaining to you. At the hearing, you may speak for yourself or use an attorney, a long term care (LTC) ombudsman, relative, friend or other person of your choice. You or your representative will be able to have witnesses at the hearing to speak on your behalf.

A copy of this notice has been mailed to the Michigan Department of Community Health and a family member or your legal representative (if applicable).

If you need assistance, you may contact:

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| Sarah Slocum, State Ombudsman<br>Michigan Department of Community Health<br>P. O. Box 30676, Lansing, MI 48909<br>Toll Free: 1-866-485-9393 | Michigan Protection & Advocacy Services<br>4095 Legacy Parkway, Suite 500<br>Lansing, MI 48911-4263<br>Phone: 1-800-288-5923 or (517) 487-1755 |

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|---|---|
| Signature of Facility/Agency Administrator<br><br>**X** | Date |

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|---|---|
| cc: | |

**Please notify the Department if the transfer/discharge is canceled or if the resident voluntarily agrees to a discharge or transfer to another facility.**